STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155154	A. BUILDING _____ B. WING _____	C 11/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL MEADOWS	2140 W 86TH ST INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This visit was for the Investigation of Complaints IN00138633, IN00138771 and IN00139479.

This survey was in conjunction with a Post Survey Revisit (PSR) to the PSR to the investigation of Complaints IN00131445, IN00131970, IN00133446 completed on 08/01/13.

This survey was in conjunction with a Post Survey Revisit (PSR) to the investigation of Complaint IN00136811 completed on 09-26-13.

Complaints:
IN00138633 Substantiated. No deficiencies related to the allegations are cited.

IN00138771 Substantiated. Federal/State deficiencies related to the allegation is cited at F314 as past non compliance.

IN00139479 Substantiated. No deficiencies related to the allegations are cited.

Survey dates:
November 8, 13, 14, 15, 18 and 20, 2013

Facility Number: 000074
Provider Number: 155154
AIM Number: 100290050

Survey Team:
Mary Jane G. Fischer RN

Census Bed Type:
SNF: 18
SNF/NF: 101
Total: 119

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155154	A. BUILDING _____ B. WING _____	C 11/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL MEADOWS	2140 W 86TH ST INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 Census Payor Type: Medicare: 20 Medicaid: 71 Other: 28 Total: 119 Sample: 9 Spring Mill Meadows was found to be in complaince with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the investigation of complaint IN00138771, IN00139479, and IN00138633. Quality Review was completed by Tammy Alley RN on November 25, 2013.	F 000		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure a resident did not acquired a pressure ulcer, in that when a residents entered the facility without a pressure ulcer, acquired a pressure ulcer which progressed in size and	F 314	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155154	A. BUILDING _____ B. WING _____	C 11/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL MEADOWS	2140 W 86TH ST INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 2	F 314		

required intervention by a wound care specialist at the facility and also at a local area hospital.

This deficient practice effected 1 of 1 resident's in a sample of 9 who acquired a pressure ulcer after admission to the facility. The resident eventually was transported to a local area hospital, but was unable to recover from the surgical interventions required and expired at the hospital. (Resident "B").

Findings include:

The record for Resident "B" was reviewed on 11-08-13 at 1:20 p.m. Diagnoses included, but were not limited to, open reduction and internal fixation of femur, hypertension, impaired renal function and constipation. These diagnoses remained current at the time of the record review.

At the time the resident was admitted to the facility on 07-01-13, the resident had a left hip incision with "staples intact."

The physician History and Physical, dated 07-03-13 indicated the resident had "no rash," and "no pressure ulcer."

The admission MDS (Minimum Data Set assessment) dated 07-08-13, indicated the resident was frequently incontinent of bowel and bladder, required extensive assistance with transfer, bed mobility, toileting and hygiene. The assessment indicated the resident had limited range of motion to the lower extremity, with no pressure ulcers at the time of the assessment, but was identified "at risk for pressure ulcers."

The resident's plan of care, dated 07-10-13,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155154	A. BUILDING _____ B. WING _____	C 11/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL MEADOWS	2140 W 86TH ST INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 3	F 314		

identified the resident "at risk for skin breakdown due to decreased mobility, frequent incontinence and risk associated with anemia." The goal to this "problem" indicated "resident will be free from skin breakdown." The record lacked documentation of an approach to this problem.

A subsequent MDS, dated 07-13-13, and identified as a "14 day assessment," indicated the resident remained at risk for pressure ulcers but at the time of the assessment the resident did not have a pressure ulcer.

The 07-10-13 plan of care was updated on 07-15-13 to include "assess and document skin condition weekly and as needed, turn and reposition often, pressure reducing/redistribution mattress on bed, incontinent care as needed using periwash and moisture barrier, encourage resident to eat at least 75 % of meals, assess and document skin condition weekly and as needed. Notify MD of abnormal findings."

The nursing progress notes indicated the following in regard to the resident's skin:

"07-12-13 at 10:50 p.m. ... dressing to left hip c/d/i [clean/dry/intact], no drainage, redness or warmth noted. Excoriation noted this shift on left hip under staples, appears to be from the removal of tape from current tx. [treatment] to hip, paged MD [Medical Doctor] for order, awaiting call back, monitoring. Call light in reach, will continue to monitor."

"07-13-13 at 1:54 a.m. Excoriation to lt. [left] hip due to tape is covered, no drainage noted. Will continue to monitor."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155154	A. BUILDING _____ B. WING _____	C 11/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL MEADOWS	2140 W 86TH ST INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 4	F 314		

"07-14-13 at 11:40 p.m. Left hip dressing c/d/i, excoriation noted to "L" [left] hip from tape. Nursing removal, no c/o [complaints of] pain or discomfort, will continue to monitor."

"07-15-13 at 11:29 a.m. Excoriation to "L" hip remains. Seems to be healing."

"07-15-13 at 10:53 p.m. Tx. [treatment] to hip/buttocks area tolerated well, area remains reddened, no s/s [signs or symptoms] of infection, no drainage noted."

"07-19-13 at 1:32 a.m. ...excoriation noted to "L" hip from tape removal, no c/o pain or discomfort, will continue to monitor."

"07-19-13 at 11:11 a.m. Res. [resident] does have round reddened area to "L" hip lateral to where incision is. Area blanches well and res. [resident] denies pain or discomfort. Res. will be encouraged to reposition often. Will continue to observe."

"07-22-13 at 9:39 a.m. ... c/o pain to coccyx wound, res. is on schedule pain meds and effective. Skin on coccyx has wound that has a tx., wound has is [sic] black, with drainage, excoriation around area. Staff will continue to monitor."

"07-22-13 at 6:07 p.m. Res. started on ABT [antibiotic] for coccyx wound, left message on family answering machine."

"07-22-13 at 6:56 p.m. [Family member] came to nurses station and requested update on wound to sacrum. This nurse updated [family member] by telling of current tx and appearance of wound.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155154	A. BUILDING _____ B. WING _____	C 11/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL MEADOWS	2140 W 86TH ST INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 5	F 314		

This nurse spoke to [name of physician] regarding current tx. and MD stated to cont. [continue] current tx until seen by wound nurse. Will cont. to observe."

"07-22-13 at 10:10 p.m. ... treatment to coccyx done as ordered, c/o pain during dressing change, resident on routine pain medication. ATB for wound, no adverse side effects, incision to "L" hip is healed, will continue to monitor."

"07-23-13 at 2:43 a.m. Dressing change done. Area is black, redness noted surrounding, small amt. [amount] of drainage noted. No odor. Hardness noted to area. c/o pain during change."

"07-25-13 at 7:22 a.m. Pt tx to buttocks done this shift. Pt. wound is black in color, periwound red with slough noted. Pt had no drainage or odor noted at this time. Pt. is currently on ATB therapy with s/sx [sic] of adverse reactions. Will cont. to monitor."

"07-26-13 at 4:11 p.m. Res. was seen by wound care specialist today and new orders rec/d [received]. Call placed to dtr in law per dtr's request to update her on new orders."

"07-27-13 at 12:06 a.m. On ATB therapy, [name of physician] paged about elevated temperature. Waiting orders, will monitor. Tx. noted to buttocks. Call light in reach will continue to monitor."

"07-27-13 at 4:06 p.m. IDT [interdisciplianary team] wound review and NAR [nutritional at risk]. Sacral wound presents as 75 % slough, 25 % pink gran. [granulation] small amt. [amount] of sero-sanguinous drainage, no s/sx [signs or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155154	A. BUILDING _____ B. WING _____	C 11/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL MEADOWS	2140 W 86TH ST INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 6	F 314		

symptoms] of infection, peri-wound normal, noted pain to area. Current tx. Xenaderm/foam dressing to sacral. Intervention: low air loss mattress, ROHO cushion in wheelchair, to be followed by wound care specialist. Recommendations: DC [discontinue] current treatment, start barrier cream to peri-wound, Santyl and NS [normal saline], fluffed gauze."

"07-30-13 at 11:11 a.m. [Family member] called and requested to speak with the wound nurse that eval. [evaluated] her [resident] this past wk. [week] so she could get more info on her wound. Informed [family member] this nurse would notify wound nurse to contact her."

"07-30-13 at 12:24 p.m. ED [executive director] spoke with wound NP [nurse practitioner] and she stated she could contact [family member] at some point today to update on res [resident's] wound."

"07-30-13 at 6:42 p.m. Tx. to buttock done per order. Black tissue remains to coccyx, some serosanguinous drainage noted. Excoriation area to right buttock noted."

"08-01-13 at 2:46 a.m. Dressing to coccyx/buttocks CDI [clean, dry and intact]. Denies pain at this time. Vitals WNL [within normal limits] No adverse reaction to ATB tx. afebrile. ATB tx done today."

This nurses note entry was then marked as "invalid" and the following entry was documented in the resident record:

"08-01-13 at 2:46 a.m. Dressing to coccyx/buttocks soiled, changed times 2, after 3 loose stools, area is black with red excoriation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155154	A. BUILDING _____ B. WING _____	C 11/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL MEADOWS	2140 W 86TH ST INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 7	F 314		

surrounding, large amt. of brown red discharge, foul odor noted. Will continue to monitor."

"08-01-13 at 3:55 p.m. Resident resting in bed. Dressing on sacrum changed times 3 today due to loose stools. Stools have foul odor. Wound is black with excoriation surrounding. Will continue to monitor. Resident cont. on ABT."

"08-02-13 at 11:13 a.m. Dressing changed to sacrum. Wound is black surrounded by excoriation. Continent of bowel and bladder."

"08-02-13 at 3:33 p.m. Wound care NP here to eval. [evaluate] res. Wound to sacrum requires debridement. NP stated she would call [family member] to explain details of the wound."

"08-02-13 at 4:47 p.m. IDT wound review: NP at bedside, sacral wound presents as 75 % slough, 25 % gran [granulation], mod [moderate] amount of sero-sanguinous drainage, signs of infection noted, strong odor, peri-wound normal, noted pain to area, wound deterioration noted. NP spoke with family regarding wound debridement... DC current treatment, start Dakin's 1/4 strength, now order for ABT... ."

"08-05-13 at 3:59 a.m. Dressing change to buttocks, adherent, black soft eschar is continuing to soften, OA [sic] able to see tissue, deep. Moderate amt of serosanguinous drainage noted, no foul odor. Surrounding skin is reddened, cream applied. C/o increase discomfort [sic] during change."

"08-06-13 2:21 a.m. During dressing change c/o pain. Moaning throughout entire tx. Wound area is adherent soft black eschar with non-adherent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155154	A. BUILDING _____ B. WING _____	C 11/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL MEADOWS	2140 W 86TH ST INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 8	F 314		

yellow slough. Moderate amt. of serosanguinous drainage. No odor. Surrounding skin is red, barrier applied. During peri-care, noted vaginal blood when wiping, DR [doctor] notified, stated 'since res. is transferring tomorrow tell family in a.m. and ask what they would like to do wether [sic] us take care of vaginal blood when wiping or new facility.'"

"08-06-13 at 1:19 p.m. Resident discharged to another facility on this day. Treatment done to coccyx before discharged. Res. wound was still black in color with odor and drainage noted. Res. screamed in pain... ."

A subsequent plan of care dated 07-25-13, indicated the resident had "impaired skin integrity on sacral area." "Approaches," dated 07-25-13, included Wedge cushion while in bed, RD [registered dietician] to assess routinely for nutritional needs of resident to enhance wound healing, no briefs in bed, labs as ordered, eval. by wound care specialist, and encourage res. to position side to side."

Subsequent "approaches," dated and included "07-26-13 ROHO cushion to wheelchair, 07-27-13 wound healing vitamins as ordered, treatment as ordered, observe for signs of infection: redness, pain, drainage, malodorous drainage, fever, increase in size/depth of wound, notify MD of worsening or no change in wound or for signs of infection, incontinent care as needed, encourage resident to eat at least 75 % of meals, assess wound weekly documenting measurements and description, assess for pain, treat as ordered. Notify MD of unrelieved worsening pain."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155154	A. BUILDING _____ B. WING _____	C 11/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL MEADOWS	2140 W 86TH ST INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 9	F 314		

Shower Reports
The directions at the top of this document prompted the CNA (certified nurses aide) to "circle problem area and check all boxes as needed." The areas included, but were not limited to, open areas, rash, redness, blisters and skin tears. The document indicated the charge nurse needed to sign the shower report and prompted the nurse "all skin problems must be assessed and documented by the charge nurse. Behaviors will be included on the Behavior Monitoring Sheet. Any shower refusal must be recorded with a second attempt tried."

Review of the "shower reports, dated 07-11-13 indicated the resident refused and the licensed nurse was notified, 07-18-13 indicated the resident refused and the licensed nurse was notified, 07-29-13 indicated the resident received a shower and "cries," and 07-31-13 complete bad bath given on two occasions on this date and the licensed nurse notified.

Further review of the "Shower Reports," from the above noted dates lacked identification of the resident's buttocks, open area, rash, redness, blisters or skin tears.

Event Reports
Review of the nursing event reports for the resident included the following:

a. "Event date: 07-22-13.
Date recorded: 07-26-13 at 6:48 p.m.
Completed date: 07-26-13 at 6:51 p.m.

Description Sacrum - existing area, not present on admission, originally noted on 07-14-13, unstageable with slough (yellow or white tissue

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155154	A. BUILDING _____ B. WING _____	C 11/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL MEADOWS	2140 W 86TH ST INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 10	F 314		

adhering to ulcer bed), which measured 8.0 cm in length by 8.0 cm in width by 0.1 cm depth, with 90 % slough and 10 % granulation, sm. [small] amount of serosanguinous drainage, no odor. Current treatment: Normal saline, Xenaderm, ABD [dressing], transparent drsg, dly [daily] and PRN [as needed]. Notifications: Family - NO"

b. "Event date: 07-26-13.
Date recorded: 07-26-13 at 6:40 p.m.
Date completed 07-26-13 at 6:46 p.m.

Description Sacrum - existing area. Dated originally noted 07-14-13, unstageable, slough, measurements 7.6 cm by 8.7 cm by 0.6 cm, 90 % slough and 10 % granulation. Small amount of serosanguinous drainage with no odor. Current treatment Santyl, hydrogel moistened gauze then cover with dry gauze daily and PRN soilage. Notifications: Family - NO"

Local Wound Care Consultant reports

a. "07-26-13 Chief complaint: patient presents with pressure ulceration. context: started as indurated area that then turned black malodorous - new within the last few weeks.
Wound #1 Sacral is a necrotic tissue (unstageable) pressure ulcer and has received a status of not healed. Measurements are 7.6 cm in length by 8.7 cm in width, by 0.6 cm in depth. The patient reports a wound pain of level 1. Wound bed is 76 % - 100 % slough, 1-25 % granulation."

b. "08-02-13 Pressure ulcer has received a status of not healed. Measurements are 7.6 cm in length by 8.7 cm in width by 1 cm in depth, with muscle exposure and a moderate amount of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155154	A. BUILDING _____ B. WING _____	C 11/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL MEADOWS	2140 W 86TH ST INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 11	F 314		

sero-sanguineous drainage noted which has a strong odor. The patient reports a wound pain of level 8. The wound is deteriorating. Poor PO [by mouth] intake, not eating well despite encouragement; recent change in medications and pt. moaning during assessment with face grimace; spoke to daughter in law regarding debridement. I am waiting for a return call from [family members] for consent to debride. High likelihood of bone exposure with debridement."

Interview on 11-15-13 at 11:30 a.m. the Wound Care NP indicated "By the time I saw it, it was black and there was an odor. I didn't talk to any family member after the first visit. It had a moderate amount of pink drainage. I think I talked to them the same day, I think the second visit, when I thought it needed to be debrided, I can't be sure, but they didn't want it at that point."

Interview on 11-15-13 at 11:30 a.m., the Registered Nurse for the Wound Care Company indicated the resident's [family member] called me and I spoke to her. She was asking about anemia and wound healing - I referred her to the primary doctor for those issues.

Therapy notations

a. Review of the Occupational Therapy Daily Notations, dated 07-26-13 indicated, "Provision of ROHO cushion to increase pt. comfort while seated in w/c [wheelchair] and decrease risk of further pressure wounds." "07-29-13 Air added to ROHO cushion to increase pt comfort and to alleviate pressure when sitting up in w/c." "07-30-13 Pt ROHO cushion low, added air to increase effectiveness of cushion for alleviating pressure and improved pt. comfort while seated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155154	A. BUILDING _____ B. WING _____	C 11/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL MEADOWS	2140 W 86TH ST INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 12	F 314		

in w/c." "07-31-13 Pt. ROHO cushion low again this date, not holding air sufficiently. New ROHO cushion obtained and placed to improve pressure relief and pt. comfort while up in w/c."

b. Occupational Therapist Progress and Updated Plan of Care, dated 08-01-13.

"Impact on Burden of Care / Daily Life: Complicating factors, including's wound an pain prevent the patient from achieving all established goals."

c. Physical Therapist Daily treatment notes:
"07-31-13 Patient c/o pain on the lumbar area (wound) ... .
"08-02-13 Patient ambulated and tolerated 15 feet times two due to pain lower back area using standard walker with min [minimum] assist and encouragement to increase distance, frequent verbal cues for upright posture."

"08-01-3 - Physical Therapist Progress & Updated Plan of Care - Impact on Burden of Care / Due to safety reasons, the patient requires verbal and occasional tactile cues for safety in transfer. Complicating factors, including pain wound area (lower back) and occasional pain "L" hip (recent surgery) prevent the patient from achieving all established goals."

"08-21-13 [sic] Therapist Progress & Discharge Summary - Impact on Burden of Care / Daily Life Complicating factors, including pain on the wound area (sacral) prevent the patient from achieving all established goals. Dischaged to another SNF [skilled nursing facility]."

9. A review of the hospital record on 11-14-13 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155154	A. BUILDING _____ B. WING _____	C 11/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL MEADOWS	2140 W 86TH ST INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 13	F 314		

8:30 a.m. indicated the following:

The resident was taken to the local area hospital emergency room on 08-06-13. While in the emergency department, the hospital physician documented the resident had "about a 10 cm [centimeter] sacral decubitus - deep to coccyx [bold print] and malorderous [bold print]. Wound Care nurse in room - decubitus quite impressive malodorous. Deep (to coccyx) thick layer necrotic tissue. Edges look okay. Hospitalization for wound care."

The assessment and measurements recorded in the hospital record, by the Wound Care nurse, included the following: "Sacro-coccygeal pressure ulcer with 60 % slough which was gray, white and yellow in color. Length 10 cm, width 8 cm and depth 6 centimeters. Pressure wound stage - stage 4 [Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling], with moderate wound drainage, serosanguinous with a foul odor. Referral to see pt. [patient] down in ER [emergency room]. Pt. came in with stage 4 pressure ulcer to her sacrum/coccyx. Called [name of physician] for debridement of necrotic tissue. Pt. given 2 separate doses of 2 mg [milligrams] morphine for pain with wound care."

The wound care consultation and physician procedure report, dictated by the physician who did the debridement, indicated the following:

"Her only complaints right now are sacral pain when manipulated or turned and the patient also has a left hip that had a partial arthroplasty.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155154	A. BUILDING _____ B. WING _____	C 11/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL MEADOWS	2140 W 86TH ST INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 14	F 314		

Examination of her sacral ulcer, which was done yesterday, revealed a huge mass of grossly gangrenous necrotic tissue extending from a very large state 4 sacral ulcer. This was foul smelling, had purulent drainage. There was palpable bone or coccyx in 1 portion of the wound. Debridement was carried out in the emergency room by myself. Impression: 1. Huge sacral decubitus ulcer stage 4, 2. cognitive function intact - Patient mentally clear, 3. Severe hearing deficit, 4. Bedridden secondary to impaired left hip status post surgery, 5. Gangrenous necrotic tissue, most of which has been already debrided. The date of this procedure was August 6, 2013 in the [name of local area hospital] emergency room. Findings: Besides the gangrenous necrotic tissue described patient has raw coccygeal bone or cartilage that is somewhat movable, but otherwise intact."

The hospital Infectious Disease Consult indicated the reason for the consultation was for the "decubitus ulcer." "About 2 weeks ago, the patient started developing what seems to be a decubitus ulcer in the sacrum and she was initially stated on intravenous antibiotics for 2 weeks. The patient was having worsening pain on the sacrum and for that reason she was brought to the hospital for further management. The back shows a very large ulceration involving the sacrococcygeal area. This measure probably between 15 and 20 cm in diameter. Some of the edges of this wound are necrotic, mostly on the superior portion. The base of the wound also has some tissue necrosis. The sacrum is easily palpated and towards the coccygeal area there seems to be a portion of the coccyx that has fractured. There is a small piece of bone essentially attached only to soft tissue.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155154	A. BUILDING _____ B. WING _____	C 11/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL MEADOWS	2140 W 86TH ST INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 15	F 314		

Impression: 1. Large decubitus ulcer. The fact that I am able to palpate a piece of bone that seems to have fractured from the coccyx is very concerning. This wound require a very large incision and debridement including removal of the dislodged bone, cleaning of the bone and cleaning of the wound bed which will essentially make the wound even bigger that what it is right now. To definitely close this problem she may need a muscle flap and there is a good change that a diverging colostomy might also be needed. In all, her clinical states seems not to be fit to undergo these very extensive surgical procedures. At this point in time, I do not see any benefit from antibiotics alone. Her prognosis then is rather poor."

The resident was transferred to a Speciality Hospital and expired on 09-04-13.

During an interview on 11-13-13 at 11:40 a.m., a concerned family member indicated, "we were not notified until it [in regard to the pressure ulcer] was a stage 4. I visited a lot and no one said anything. I know [resident] died from all of this."

During a subsequent interview with the resident's responsible party on 11-14-13 at 10:50 a.m., indicated "They told me it, an area looked like a reaction to bandage tape and then later [name of licensed nurse #9] said it might have been a blister that popped open. When I would ask about it, [named of licensed nurse #9], well she wasn't definite but kept saying [resident] was fine and healing. The next day she told me [resident] was complaining about her bottom hurting and looked awful. When I saw it, it was a Stage 4. that's the first time I saw it - black and oval - it was longer than it was wide and it was big. We

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155154	A. BUILDING _____ B. WING _____	C 11/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL MEADOWS	2140 W 86TH ST INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 16 took [resident] to [name of local area hospital] and the doctor said it was bad and all the way to the bone. I confronted [name of licensed nurse #9] because no one ever said it was a bed sore. I would guess it was about 2 1/2 inches wide and 4 inches in length but I'm just guessing. All I can tell you was it was big." This survey resulted in past non-compliance that began on 07-14-13. The past non compliance deficient practice was corrected 09-26-13 after the facility implemented a systemic plan that included the following actions: The employment of a Unit Manager with Long Term Care and extensive Wound treatment background, the employment of a weekend Supervisor in the building 12 - 16 hours per day and who also attended Friday afternoon administrative meetings to get updates on the High Risk Residents, the implementation of Nursing Management daily rounds on resident's with wounds, Skin Sweeps monthly at the minimum, notification of the Director of Nursing Services for change of conditions to help in decreasing hospitalizations and increasing critical thinking skills for the Long Term Care nursing staff and a proactive approach with preventative wound care. This Federal tag relates to Complaint IN00138771. 3.1-40(a)(1) 3.1-40(a)(2)	F 314		